No. 89-682

In The

Supreme Court of the United States

October Term, 1989

THE STATE OF COLORADO DEPARTMENT OF SOCIAL SERVICES, and IRENE M. IBARRA, Executive Director of the State of Colorado Department of Social Services,

Petitioners,

v.

AMISUB (PSL), d/b/a/ AMI St. Luke's Hospital, Inc., AMI Presbyterian Denver Hospital, Inc., and AMI Presbyterian Aurora Hospital, Inc.,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

PATRIC HOOPER
HOOPER, LUNDY & BOOKMAN, INC.
Fox Plaza, Suite 430
2121 Avenue of the Stars
Los Angeles, CA 90067-5010
(213) 551-8165

Attorneys for Respondents

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTION PRESENTED

Whether a Medicaid provider has a private federal cause of action under 42 U.S.C. Section 1983 to enforce the Medicaid Act against a state.

RULE 29.1

Pursuant to the requirements of Rule 29.1 of the United States Supreme Court, the affiliates of AMISUB (PSL) and the hospitals pursuant to which AMISUB (PSL) does business are the subsidiaries of American Medical International, Inc., the parent company of AMISUB (PSL). During all times relevant herein, American Medical International, Inc., was a publicly-owned health care company. It is now privately owned by IMA. Holdings Corp., an investment partnership formed by Harry Gray, Mel Klein, and Partners LP and First Boston Investments, Inc.

TABLE OF CONTENTS

Page

QUESTION PRESENTED i

TABLE OF CONTENTS ii

TABLE OF AUTHORITIES iii

OPINIONS BELOW 2

JURISDICTION 2

STATUTORY PROVISION INVOLVED 3

STATEMENT OF THE CASE 3

ARGUMENT 3

CONCLUSION 7

TABLE OF AUTHORITIES – Continued

Page

CASES

Colorado Health Care Ass'n v. Colorado Dept. of Social Services, 842 F.2d 1185 (10th Cir. 1988) 7

STATUTES

28 U.S.C. § 1254(1) (1982) 2

42 U.S.C. § 1983 ..... 3, 4

REGULATIONS

42 C.F.R. § 447.253(c) [1987] 4

No. 89-682

In The

Supreme Court of the United States

October Term, 1989

THE STATE OF COLORADO DEPARTMENT OF SOCIAL SERVICES, and IRENE M. IBARRA, Executive Director of the State of Colorado Department of Social Services,

Petitioners,

v.

AMISUB (PSL), d/b/a/ AMI St. Luke's Hospital, Inc., AMI Presbyterian Denver Hospital, Inc., and AMI Presbyterian Aurora Hospital, Inc.,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

Pursuant to the request of the Court, as communicated by the Court Clerk in his December 20, 1989 letter to counsel, respondents AMISUB (PSL) d/b/a AMI St. Luke's Hospital, Inc., AMI Presbyterian Denver Hospital, Inc. and AMI Presbyterian Aurora Hospital, Inc. ("Hospitals"), appellants below, file this Response to the Petition for Writ of Certiorari.

As the sole ground for their petition, the State of Colorado Department of Social Services, and Irene M. Ibarra, Executive Director of the State of Colorado Department of Social Services (the "Colorado Medicaid Agency") raises the issue of whether a Medicaid provider has a private federal cause of action under 42 U.S.C. Section 1983 to enforce the Medicaid Act against a state. This is the very same issue on which certiorari was granted in *Gerald L. Baliles, et al. v. Virginia Hospital Association*, No. 88-2043, argued January 9, 1990.

Because the Court granted certiorari in *Baliles* and because that case has been fully argued on the merits, this response to the instant Petition for Certiorari will be limited to emphasizing certain critical facts and assertions applicable to this case.

OPINIONS BELOW

The opinion of the United States District Court for the District of Colorado is not reported and is set forth in the Appendix to the Petition for Certiorari at Appendix 1. The opinion of the United States Court of Appeals for the Tenth Circuit is reported at 879 F.2d 789 and is set forth in the Appendix to the Petition for Certiorari at Appendix 11.

JURISDICTION

The jurisdiction of this Court is invoked under 28 U.S.C. Section 1254(1) (1982). The decision of the Court of

Appeals was rendered on July 11, 1989, and a petition for rehearing with suggestion for rehearing en banc was denied August 31, 1989.

STATUTORY PROVISION INVOLVED

The applicable statutory language is contained in the Petition at page 1.

STATEMENT OF THE CASE

The Hospitals adopt by reference the statement of the case contained in the opinion of the United States Court of Appeals for the Tenth Circuit set forth in the Appendix to the Petition at 12-16.

ARGUMENT

If the Court decides unequivocally in *Baliles* that Medicaid providers have a private federal cause of action under 42 U.S.C. Section 1983 to enforce the Medicaid Act against a state, the Colorado Medicaid Agency's Petition for Certiorari will have to be denied. However, if the Court's opinion is limited in some manner to the facts of the *Baliles* case, the following facts of the instant case are critical and compel a denial of the Colorado Medicaid Agency's Petition without regard to the outcome in *Baliles*.

First, the Hospitals were expressly precluded from administratively challenging the use of the budget adjustment factor ("BAF"), the factor which caused the Medicaid payment rates in question to violate federal Medicaid law. *See* Joint Pretrial Order, Stipulated Facts, para. 11, Appendix at 10. Thus, the regulatory provision, 42 C.F.R. Section 447.253(c) [1987], requiring states to provide appeals or exception procedures for individual providers was meaningless because the State Medicaid Agency precluded any challenge to the BAF, the fatal flaw in Colorado's Medicaid payment system.

Second, as a result of the lack of a viable administrative appeal process to challenge the BAF, the Hospitals sought prospective relief in federal court to enjoin the use and application of the BAF. The suit was initiated and temporary relief was sought prior to the effective date of the new payment rates, July 1, 1988. No eleventh amendment concerns were thus engendered since no type of retroactive relief or relief in the form of money damages was sought against individual state officials.

Third, in the trial court, the Colorado Medicaid Agency agreed and stipulated that the federal district court had federal question jurisdiction to resolve the issues presented. Pretrial Order, Jurisdiction, Appendix at 2. The State Medicaid Agency raised no objection to the Hospitals' standing or to their right to maintain a private right of action under 42 U.S.C. Section 1983. Pretrial Order, Claims and Defenses, Appendix at 2-4. Rather, over the objection of the Hospitals, the State Medicaid Agency raised the standing and private right of action issues for the first time on appeal.

Fourth, notwithstanding its assurances to the federal government to the contrary, the Colorado Medicaid Agency did not engage in the finding process required by federal Medicaid law and regulations. The Court of Appeals characterized the State Medicaid Agency's conduct as "flagrantly devoid of any effort to make the federally required findings." Appendix to Petition at 27. For example, the State Medicaid Agency admitted that it made no effort to determine which Colorado hospitals were efficiently and economically run. It also admitted that it did not determine the costs that must be incurred by the efficiently and economically operated hospitals. Appendix to Petition at 27.

Even if, for argument purposes only, Medicaid providers have no private right to obtain court enforcement of any particular *substantive* payment rate, they certainly must have access to a federal court to assure that a state Medicaid agency complies with the *procedures* required by Medicaid law and regulations.

Fifth, although the State Medicaid Agency did *not* engage in the finding process required by the federal Medicaid law and regulations, it nevertheless "assured" the federal government in 1988, that it had made the appropriate findings. *See* Joint Pretrial Order, Stipulated Facts, para. 13, Appendix at 11. Thus, it cannot be presumed that state Medicaid agencies will have actually done what they assure the federal government they have done.

Sixth, due to the extremely limited oversight role of the federal government and its practice of accepting assurances at face value, the federal government took no

action on the July 1988 assurances until *after* the Court of Appeals invalidated the BAF in July 1989. The federal government delayed its action notwithstanding the lack of an actual finding process, and the issuance of the federal district court decision which expressly revealed that the BAF had nothing to do with hospital costs and that no Colorado hospital would receive reimbursement for its costs no matter how efficiently and economically operated. *See* Appendix to Petition at 6-7. Thus, the federal government's "monitoring" is not an adequate safeguard to assure compliance with federal law.[1]

Seventh, although a "zone" of permissible rates might generally serve to satisfy a State Medicaid Agency's obligation under the federal efficiency and economy requirement, judicial review is necessary to assure that the zone is not stretched beyond rationality. This case demonstrates the need for federal court review to assure such rationality. If the appellate court had not intervened, the State Medicaid Agency would have continued to implement payment rates which, due to the BAF, did not reimburse the costs of *any* Colorado hospitals, *even* the most efficiently and economically operated hospitals.[2]

---

[1] If judicial intervention had not occurred, the mere recitation of the "magic words" in the assurances submitted to the federal government would have apparently been sufficient to the federal government thus completely eviscerating the federal requirements. *See* Appendix to Petition at 29.

[2] The United States Court of Appeals for the Tenth Circuit has appropriately recognized its limited role in reviewing the

(Continued on following page)

Eighth, the Court of Appeals appropriately limited the relief required to enjoining the application of the BAF. It did *not* invalidate the entire payment system. It did *not* even rule out the possibility that an appropriately determined BAF could be applied in the future. The Court's opinion simply and correctly served to compel the State Medicaid Agency to adhere to the applicable procedural and substantive requirements of the Medicaid law and regulations in connection with developing changes in Medicaid payment rates.

CONCLUSION

The Court is respectfully requested to consider the above in ruling on the Colorado Medicaid Agency's Petition for Certiorari.

DATED: January 17, 1990.

Respectfully submitted,

PATRIC HOOPER, a Member of
HOOPER, LUNDY, & BOOKMAN, INC.

(Continued from previous page)

substance of state Medicaid payment rates under the Medicaid law and regulations. Indeed, in *Colorado Health Care Ass'n v. Colorado Dept. of Social Services*, 842 F.2d 1158 (10th Cir. 1988), the court upheld certain changes in Medicaid payment rates for long term care services established by the very same state Medicaid agency in question. In the instant case, however, the BAF was so arbitrary that it unquestionably caused the resulting payment rates to violate the applicable federal Medicaid payment criteria.

APPENDIX

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 88-F-1024

AMISUB (PSL), INC., d/b/a AMI ST. LUKE'S HOSPITAL, INC.,
AMI PRESBYTERIAN DENVER HOSPITAL, INC., and
AMI PRESBYTERIAN AURORA HOSPITAL, INC.,

Plaintiffs,

vs.

THE STATE OF COLORADO DEPARTMENT OF SOCIAL SERVICES, and IRENE M. IBARRA, EXECUTIVE DIRECTOR OF THE STATE OF COLORADO, DEPARTMENT OF SOCIAL SERVICES,

Defendants.

JOINT PRETRIAL ORDER

(Filed Aug. 8, 1988)

I. *DATE AND APPEARANCES*

This Pretrial Order is presented for the Court's consideration on August 8, 1988. Plaintiffs (hereinafter "Plaintiff Hospitals") appear by L. Richard Freese, Jr., Esq. and Sharon E. Caulfield, Esq., of Davis, Graham & Stubbs, and by Patric Hooper, Esq., of Hooper, Lundy & Bookman, Inc. Defendants (hereinafter "The State Medicaid Agency") appear by Wade Livingston, First Assistant Attorney General, and Vivianne Oates, Assistant Attorney General, of the Office of the Attorney General, State of Colorado.

II. *JURISDICTION*

This Court has jurisdiction to resolve the federal questions in dispute pursuant to 28 U.S.C. § 1331, 28 U.S.C. § 1361, and 42 U.S.C. § 1983.

III. *CLAIMS AND DEFENSES*

A. Plaintiff Hospitals contend:

1. That due to the application of a State budget factor, the Medicaid payment rates for inpatient hospital services produced under 10 C.C.R. 2505-10, Sections 8.356 and 8.351.40 (which went into effect July 1, 1988), are not reasonable or adequate to meet the costs that must be incurred by efficiently and economically operated hospitals in the provision of services in conformity with applicable state and federal laws, regulations, and quality and safety standards. As a result, the application of the budget factor causes the State Medicaid payment rates to violate the requirements of the governing federal Medicaid statute and regulations.

2. That in establishing the final payment rates, the State Medicaid Agency did not analyze, determine or define (a) efficiently and economically operated providers, (b) the costs that must be incurred by such providers, or (c) a rate adequate to meet such costs.

3. That the final payment rates resulting from the application of the budget adjustment factor are arbitrary and capricious because (a) the budget adjustment factor requires the Medicaid agency to ignore various factors relevant to the determination of the costs that

must be incurred by efficiently and economically operated providers, and (b) the payment rates fail to distinguish between those providers which are efficiently and economically operated and those which are not.

4. That by limiting the final payment rates for inpatient hospital services by the legislatively mandated budget factor, the Colorado State Legislature has caused the State Medicaid Agency to violate the single state agency requirements of the applicable Medicaid statute and regulations since the State Medicaid Agency is deprived of the discretion necessary to determine final payment rates.

5. That the Court has jurisdiction to award the relief requested by Plaintiff Hospitals.

B. The State Medicaid Agency contends:

1. That the final payment rates do not represent a cut or reduction in expenditures for hospital services under the Medicaid program. Historically, these expenditure levels have been sufficient to enlist enough providers so that hospital services were available to Medicaid recipients at least to the extent that those services are available to the general public. Further, these historical expenditure levels were made under a state plan approved by the Secretary of the United States Department of Health and Human Services. Accordingly, the Department contends that its determination that the rates are reasonable and adequate to meet the costs of efficiently and economically operated facilities is not arbitrary and capricious.

2. That the State Medicaid Agency has made all necessary findings and assurances required by Federal law.

3. That, under the doctrine of primary jurisdiction, the Court should defer ruling in this case until the Federal Health Care Financing Administration ("HCFA") has completed its review of the new system for determining payment rates.

4. That the State Medicaid agency meets all Federal requirements of a single state agency.

5. That the Court is without jurisdiction to grant the relief sought by Plaintiff Hospitals under the Eleventh Amendment to the United States Constitution.

IV. *STIPULATIONS*

A. *Glossary of Terms.*

Plaintiff Hospitals and the State Medicaid Agency agree that the following terms shall have the following meanings for purposes of this case:

1. *Provider.* An institution that furnishes inpatient hospital services.

2. *State Medicaid Agency.* The single State agency within a State government established or designated to administer or supervise the administration of the State's Medicaid plan. In Colorado, the State of Colorado Department of Social Services is the single State agency.

3. *Health Care Financing Administration, or HCFA.* The agency within the federal Department of Health and Human Services designated by Congress to

administer the Medicaid program at the federal government level.

4. *State Plan*. A comprehensive document which is required to be established and maintained by the State Medicaid Agency and governs the administration of the State's Medicaid program.

5. *The Federal Requirement*. The requirement stated in 42 U.S.C. § 1396a(a)(13)(A) that the State Plan must provide for payment for inpatient hospital services " . . . through the use of rates . . . which the state finds, and makes assurances satisfactory to the secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality control standards. . . ."

6. *Actual Costs*. The total capital and operating costs incurred by a provider in furnishing services to its patients.

7. *Allowable Costs*. Those categories of direct and indirect capital and operating costs which are reimbursable under the Medicare "reasonable cost" standards of 42 U.S.C. § 1395x(v)(1)(A) and 42 C.F.R. § 413.1 *et seq*. Not all Actual Costs are Allowable Costs under the Medicare standards.

8. *Reasonable Costs*. That portion of Allowable Costs determined to be reasonable in amount under the Medicare reasonable cost standards.

9. *DRGs*. Diagnosis-related groups, consisting of approximately 475 clinically cohesive groupings of

inpatient hospitalizations which consume similar amounts of resources. A DRG classification generally describes a clinical category of disease.

10. *Relative Weights*. The relative weight assigned to each DRG which reflects relative resource consumption. For example, a Relative Weight of 1.00 represents a measure of the average resource consumption for the entire group of DRGs.

11. *Base Rate*. The standard payment rate to be applied under a DRG payment system, as defined in 10 C.C.R. 2505-10, section 8.356.20, paragraph 3.

12. *Routine Services*. Essentially room and board services furnished by Providers to patients.

13. *Ancillary Services*. Those hospital services for which a charge separate from the room and board charge is ordinarily made by a Provider. Examples of ancillary services include laboratory tests, x-rays, and pharmacy services.

14. *Exempt Services*. Those routine and ancillary services furnished by Providers in parts of general acute care hospitals (known as "distinct units") which are not covered by the DRG payment rates.

B. *Stipulated Facts*.

1. Plaintiff Hospitals are duly licensed by the State of Colorado to provide acute care hospital services. Plaintiff Hospitals also participate in the Colorado Medicaid program as Providers of inpatient hospital services. Plaintiff Hospitals function as tertiary care centers for the Denver area.

2. Defendant Irene M. Ibarra is the Executive Director of the State of Colorado Department of Social Services, the single State agency designated by the federal government to administer the Medicaid program in Colorado.

3. Title XIX of the Social Security Act, 42 U.S.C. Sections 1396 *et seq.*, the Medicaid law, authorizes federal grants to States for medical assistance to low-income persons who are aged, blind, disabled, or members of families with dependent children. The program is jointly financed by the federal and state governments and administered by the States. The States, in accordance with federal law, decide eligible beneficiary groups, types and ranges of services, payment level for services, and administrative and operative procedures. Payment for services are made directly by States to the individuals or entities that furnish the services. 42 C.F.R. § 430.0.

4. Under the Medicaid statute, each State is required to submit for HCFA approval a State Plan for the provision of medical assistance to eligible beneficiaries. 42 U.S.C. § 1396. The State Plan must comply with the requirements of 42 U.S.C. § 1396a and the applicable federal regulations with respect to the setting of Medicaid payment rates. 42 C.F.R. § 447.200. Modification of the methods and standards by which payment rates are determined requires a State Medicaid Agency to submit a State Plan Amendment which must be approved by HFCA [sic]. 45 C.F.R. § 205.5.

5. Under 42 U.S.C. § 1396a(a)(13)(A), a State Plan must, *inter alia*, provide for payment for hospital services through the use of rates which the State finds,

and makes assurances satisfactory to HCFA are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in the provision of services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. This is the Federal Requirement. See Glossary, p. 5.

6. HCFA has issued implementing regulations which require State Medicaid Agencies to establish payment rates consistent with, *inter alia*, the Federal Requirement. 42 C.F.R. §§ 447.250 *et seq*. The regulations also require that State Medicaid Agencies make "findings" and submit "assurances" based on such findings that the statutory requirements, including the Federal Requirement, are satisfied.

7. For hospital admissions occurring on or after July 1, 1988, the State Medicaid Agency has implemented a DRG-type system for reimbursing Colorado hospitals for providing inpatient hospital services to Medicaid beneficiaries. 10 C.C.R. 2505-10, Section 8.356. DRGs are diagnosis-related groups, consisting of approximately 475 clinically cohesive groupings of inpatient hospitalizations, which consume similar amounts of resources. A DRG classification generally describes a clinical category of disease. A relative weight is assigned to each category of disease which reflects relative resource consumption. For example, a relative weight of 1.00 represents a measure of the average resource consumption for the entire group of DRGs. Under 10 C.C.R. 2505-10, Section 356.20, a Base Rate is determined as the dollar value to be assigned to a DRG with a relative weight of 1.00. Thus, if a particular patient's discharge diagnosis is assigned a

DRG with a relative weight of 2.00 and the base rate is $1600, the payment to be made to the hospital for the patient's treatment would be equal to two times the base rate, or $3200.

8. Under 10 C.C.R. 2505-10, Section 8.356.20, paragraph 5, a separate Base Rate was determined for each of three different "peer groups" of hospitals: (a) urban hospitals, (b) rural hospitals, and (c) rural referral centers. In addition, a Base Rate is defined for out-of-state hospitals. With the exception of the out-of-state hospitals, the hospitals within each peer group are presumed by the State Medicaid Agency to have similar cost characteristics.

9. The DRG Base Rate for each peer group was calculated through the use of the peer group hospitals' *Medicare* costs per discharge. (The out-of-state hospitals peer group Base Rate is equal to a percentage of the urban hospitals' Base Rate.) Reimbursable *Medicare* costs are determined through "reasonable cost" standards set forth in 42 U.S.C. § 1395x(v)(1)(A) and 42 C.F.R. § 413.1 *et seq*. Not all Actual Costs incurred by hospitals are Allowable Costs under these Medicare reasonable cost principles. Moreover, Allowable Costs are only reimbursed to the extent they are reasonable in amount.

10. To calculate the *Medicaid* Base Rate for each peer group under 10 C.C.R. 2505-10, section 8.356.20, an average *Medicare* reimbursable cost per discharge for each peer group is calculated. This average is based on the total costs obtained from the peer group hospitals' most

recently audited Medicare/Medicaid cost reports (currently the 1985 reports) divided by the number of Medicare discharges for each hospital. The *Medicare* Allowable Cost of each hospital are adjusted to neutralize cost differences between hospitals in the peer groups resulting from differences in the severity of the conditions of the *Medicare* patients treated at each hospital. The peer group hospitals' average *Medicare* cost per discharge obtained from the 1985 cost report is updated by an inflation factor (currently approximately 3% per year) to reflect current input prices. A *Medicaid* cost per case adjustment of .88 is then applied to the average Medicare cost per discharge to obtain an average *Medicaid* cost per discharge. In applying the .88 figure, the State Medicaid Agency has assumed that the average costs for treating Colorado *Medicaid* patients are essentially 88% of the average costs of treating *Medicare* patients with the same diagnoses.

11. The State Medicaid Agency did *not* use the resulting Medicaid average cost per discharge as the peer groups' Base Rates by which the DRG relative weights are multiplied to obtain payment rates. Instead, the State Medicaid Agency reduced the average Medicaid cost for each peer group by a final adjustment factor of 46% or more. In other words, the average Medicaid cost per discharge in each peer group was reduced by nearly one-half to obtain the Base Rate for each peer group. The final adjustment factor is based on the sums historically appropriated by the State Legislature for Medicaid payment for inpatient hospital services. There are no exceptions to the application of the final adjustment factor.

12. Not all hospital inpatient services provided to Medicaid patients are subject to the DRG payment

system. For example, if a general acute care hospital provides rehabilitation or psychiatric services in a physically separate part of its hospital (*i.e.*, a "distinct part" unit), the unit is exempt from the DRG payment rates. Under 10 C.C.R. 2505-10, section 8.351.40, a "per diem" rate has been calculated by the State Medicaid Agency for total services (ancillary and routine) rendered in such distinct part units based on the average historical costs of providing Routine Services in such units at all Colorado hospitals. The costs of Ancillary Services are not included in the State's present per diem rate calculations. These per diem rates are only temporary, and may be adjusted retroactively to July 1, 1988.

13. The State Medicaid Agency amended its regulations on December 4, 1987, to incorporate the above-described methods and standards for determining payment rates for inpatient hospital services. The State Medicaid Agency submitted a Medicaid State Plan Amendment to HCFA reflecting the new DRG system in early July 1988. In the State Plain Amendment, the State Medicaid Agency assures HCFA that, *inter alia*, the payment rates produced under the new DRG system comply with all federal requirements, including the Federal Requirement.

14. Plaintiff Hospitals provide inpatient hospital services which are subject to the new DRG payment system. Plaintiff Hospitals also provide services in distinct part psychiatric and rehabilitation units which are subject to the above described per diem rates. With respect to the DRG system, Plaintiff Hospitals are members of the urban hospitals peer group. The actual average Medicaid cost per discharge for the urban peer group

is approximately $3,038. However, because of the application of the final adjustment factor, the current Base Rate for urban hospitals is only 54% of that sum, or $1,630.

15. The Colorado State Legislature has appropriated $57,427,405 for reimbursing inpatient hospital services for the fiscal year beginning July 1, 1988 (*i.e.*, the 1989 fiscal year). Of that sum, approximately $41,000,000 is projected to be paid for hospital services covered by the new DRG system. Another approximately $3,000,000 is projected to be paid for those services provided by general acute care hospitals in distinct part units, such as in Plaintiff Hospitals' psychiatric and rehabilitation units. The remainder of the appropriation is allocated to other categories of services and is not at issue. Because the total sum to be paid for inpatient hospital services is limited to the total sum appropriated by the State Legislature, there will have to be a concomitant decrease in payments to other categories of inpatient hospital services if payments in any category exceed the sums projected, unless the State Legislature appropriates supplemental funds.

16. The State Medicaid Agency has been required to request permission from the Legislature to "overspend" its 1988 fiscal year budget for inpatient hospital services since the sum appropriated for the 1988 fiscal year did not cover the actual amounts required to be paid to providers under the previous system for reimbursing providers of inpatient hospital services. If permission to overspend is granted, the additional funds will be paid out of the 1989 fiscal year appropriation.

17. The amount to be paid by the State Medicaid Agency to all hospital providers exclusive of the

final adjustment factor is projected to exceed $106,000,00 for services provided to Medicaid patients during the 1989 fiscal year. If the number of Medicaid patients exceed projections, this sum would increase. The final adjustment factor of 54% is determined by the ratio of the Legislature's budget appropriation, approximately $57,000,000, to $106,000,000. Thus, in the aggregate, hospitals will receive approximately $57,000,000 for the 1989 fiscal year Medicaid services, unless the State Legislature appropriates a supplemental amount.

C. *Stipulations Regarding Admissibility of Evidence.*

The State Medicaid Agency has no objections to the admission of Plaintiffs' Exhibits 1-13.

Similarly, Plaintiff Hospitals have no objections to the admission of the State Medicaid Agency's Exhibits A and B.

D. *The Applicable Statutes And Regulations.*

Plaintiff Hospitals and the State Medicaid Agency agree that the statutes and regulations governing this dispute are found at 42 U.S.C. § 1396 *et seq.*, 42 C.F.R. § 431 *et seq.*, 42 C.F.R. § 447.250 *et seq.*, 45 C.F.R. § 201 *et seq.*, C.R.S. § 26-4-110, and 10 C.C.R. 2505-10, §§ 8.351 and 8.356. The pertinent provisions of these statutes and regulations are included in the accompanying document entitled "Applicable Statutes and Regulations."

V. *PENDING MOTIONS*

None.

VI. *WITNESSES*

Plaintiff Hospitals intend to call the following witnesses in the following order:

1. James R. Hart
2. Dr. Garry A. Toerber (adverse witness)
3. David West (adverse witness)
4. Kathleen Means

Mr. Hart and Ms. Means will testify as expert witnesses. The State Medicaid Agency stipulates that Mr. Hart is an expert in the area of Colorado hospital costs and that Mr. Means is an expert in health care financing.

Written summaries of the opinions of Mr. Hart and Ms. Means and a description of their qualifications have been provided to the State Medicaid Agency's counsel.

The State Medicaid Agency intends to call the following witnesses in the following order:

1. Dr. Garry A. Toerber
2. David West

All of the above witnesses will be present at trial. It is possible, however unlikely, that the testimony of some of the witnesses will be offered by deposition.

Mr. Hart will testify generally about how payment rates are calculated under the new DRG system and will also speak about the background of the system. Additionally, Mr. Hart will testify regarding the payment rates produced under the new system and the costs of the Colorado hospitals to which the new payment rates are

applicable. Finally, he will give his opinion as to whether the payment rates will meet the costs of any Colorado hospitals.

Dr. Toerber and Mr. West will testify regarding the background and development of the DRG system and will also testify regarding the factors which were and were not considered in connection with developing and implementing the new DRG system and the payment rates produced thereunder. They will also testify regarding the sums appropriated by the Colorado State Legislature with respect to the new system.

Ms. Means will testify regarding HCFA's interpretation of the federal regulations governing the establishment of payment rates for inpatient hospital services and will also generally discuss the procedures by which State Medicaid Agencies are required to establish such payment rates. Additionally, she will comment on the HCFA review process associated with payment rates. Finally, she will give her opinion as to whether the payment rates in question are reasonable and adequate to meet the costs incurred by efficiently and economically operated Medicaid Providers.

VII. *EXHIBITS*

A. Plaintiff Hospitals will offer the following exhibits during trial:

1. The State regulations pertaining to the State Medicaid program, including the regulations implementing the new DRG system, Sections 8.300 through 8.373.4, consisting of 41 pages.

2. Excerpts from the training seminars presented by the Colorado Hospital Association and the State Medicaid Agency regarding implementation of the new DRG system, consisting of 32 pages.

3. A sample Medicare/Medicaid cost report form consisting of 159 pages.

4. The State Fiscal Year 1989 Medicaid Projections, prepared by the State Medicaid Agency on March 29, 1988, consisting of one page.

5. A summary sheet of various calculations relating to the new DRG system prepared by the DRG Advisory Committee, consisting of one page.

6. A Technical Issue Paper for the DRG Advisory Committee, consisting of 2 pages, dated August 21, 1986.

7. The transmittal form and accompanying materials, including the assurances transmitted by the state Medicaid Agency to HCFA with respect to the new DRG system, consisting of 36 pages.

8. The Colorado Hospital Association's calculations of the impact of the DRG system, consisting of two pages.

9. The State Medicaid Agency's June 9, 1988, letter to St. Luke's Hospital with attachments, consisting of 11 pages.

10. The State Medicaid Agency's June 9, 1988, letter to Presbyterian Denver Hospital, consisting of 11 pages.

11. Plaintiff Hospitals' July 6, 1988, letter to the State Medicaid Agency with attachments, consisting of 11 pages.

12. A list of James R. Hart's background and qualifications, consisting of one page.

13. A list of Kathleen Means' background and qualifications, consisting of one page.

14. Any exhibits necessary for impeachment and/or rebuttal.

B. The State Medicaid Agency intends to offer the following exhibits:

1. Chart summarizing appropriations and expenditures for Medicaid inpatient hospital services beginning FY 1984 through projection for the current fiscal year.

2. Rule making record concerning the Colorado Board of Social Services adoption of regulations implementing the new DRG system, sections 8.300 through 8.373.4, including the Statement of Basis and Purpose, Fiscal Impact Statement and Excerpts from the Minutes of the Board's meetings on November 6 and December 4, 1987.

3. Any exhibits necessary for impeachment, rebuttal or to complete excerpts from documents offered in evidence by the Plaintiff Hospitals.

VIII. *DISCOVERY*

All discovery has been completed.

IX. *SPECIAL ISSUES*

None.

X. *OFFER OF JUDGMENT*

Counsel acknowledge familiarity with the provisions of Rule 68, Federal Rules of Civil Procedure (Offer of Judgment) and have discussed it with the client against whom claims are made in this case.

XI. *EFFECT OF PRETRIAL ORDER*

Counsel acknowledge familiarity with the provisions of Rule 16, Federal Rules of Civil Procedure (Pretrial Procedures; Formulating Issues).

Hereafter, this Order will control the subsequent course of this action and the trial and may not be amended except by consent of the parties and approval by the Court or by order of the Court to prevent manifest injustice. The pleadings will be deemed merged herein. In the event of ambiguity in any provision of this Order, reference may be made to the records of the Pretrial Conference, if one is conducted and reported, and to the pleadings.

XII. TRIAL AND ESTIMATED TRIAL TIME

A court trial will be held in this case beginning at 9 a.m. on August 11, 1988. The parties estimate that the trial will last one day.

DATED: August ___, 1988.

Sherman G. Finesilver
United States District Judge

Presented Jointly By:

DAVIS, GRAHAM & STUBBS

/s/ Sharon E. Caulfield
L. Richard Freese, Jr.
Sharon E. Caulfield
370 17th Street, Suite 4700
Denver, Colorado 80201
(303) 892-7308

FOR THE ATTORNEY GENERAL:

/s/ Wade Livingston
Wade Livingston
Vivianne Oates
Office of the Attorney General
for the State of Colorado
1525 Sherman Street, 3rd Floor
Denver, Colorado 80203

Attorney for Defendants

HOOPER, LUNDY & BOOKMAN, INC.

/s/ Patric Hooper
Patric Hooper
Fox Plaza, Suite 430
2121 Avenue of the Stars
Los Angeles, CA 90067-5010
(213) 551-8165

Attorneys for Plaintiffs